Dr. Jordan A. Bolles D.D.S.

1020 S 40th Ave Suite F – Yakima, WA 98908 – (509) 965-7668

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE_____

NAME_____ INSURANCE_____

ADDRESS_____ SUBSCRIBER_____

CITY_____STATE_____ZIP_____ EMPLOYER_____

TELEPHONE: (HOME)_____ GROUP #_____

(WORK)_____ SOCIAL SECURITY #_____

BIRTHDATE_____AGE_____ REFERRING DENTIST_____

RESPONSIBLE PARTY (IF CHILD): EMERGENCY CONTACT_____

_____ SPOUSE'S NAME_____

HEALTH HISTORY

1. Do you have pain from any area of the mouth?_____
2. Are you in good health?_____ Date of last physical exam: _____
3. Are you now under the care of a physician?_____ Physician's name_____
4. Have you had a serious illness or condition in the last five years?_____
5. List medications you are now taking_____
   _____
   _____
6. Are you allergic or have you reacted adversely to any of the following sustances? (Please circle if yes)

Aspirin	Nitrous Oxide	Valium	Other Antibiotics
Codeine	Ibuprofen	Local Anesthetic	Sulfa
Hydrocodone	Tetracycline	Penicillin	Latex

Other (please list):_____

7. Have you ever had : (Please circle if yes)

Mitral Valve Prolapse	Bleeding Problems	Tumor or Growth	Arthritis
Heart Trouble	Stroke	Vision Problems	Rheumatic Fever
Heart Murmur	Asthma	Hearing Loss	Hepatitis Type: ____
High Blood Pressure	Anemia	Seasonal Allergies	AIDS/HIV
Diabetes	Kidney Disease	Ulcers	Chemotherapy
Artificial Joints/Valves	Tuberculosis	Epilepsy/Seizures	Radiation Therapy

8. Do you consider yourself a nervous person? _____
9. Do you smoke? _____ How much? _____
10. Do you have any disease, condition, or problem not listed above that you think we should know about? _____

_____

_____

11. FOR WOMEN ONLY: Are you pregnant? _____ What month?_____

Consent for Root Canal Treatment

Patient name_____

I hereby authorize Dr. Jordan A. Bolles to perform a root canal on tooth/teeth number(s):_____

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatments, and the doctor has explained the risks and benefits of the alternatives. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result. The doctor has explained to me that there are certain potential risks in the procedure. These include:

1. Inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth)
2. Infection that may occur and may continue, requiring further endodontic surgery or extraction
3. Fracture or breakage of the root or crown portion during or after treatment
4. Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved
5. Perforation of the tooth or root of the tooth during treatment
6. Damage to existing fillings, crowns or porcelain veneers
7. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues
8. Other:_____

Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain).

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

Please do not hesitate to ask the doctor or the staff if you have any questions.

_____Date_____

Patient, parent or guardian signature

_____Relationship_____

Printed name if signed on behalf of the patient